United States General Accounting Office

GAO

Testimony

Before the Committee on Health, Education, Labor, and Pensions, U.S. Senate

For Release on Delivery
Expected at 10:00 a.m.
Thursday, May 18, 2000

MENTAL HEALTH PARITY ACT

Employers' Mental Health Benefits Remain Limited Despite New Federal Standards

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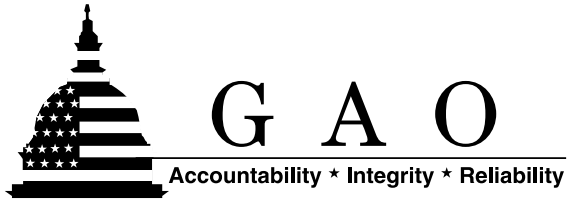

Mental Health Parity Act: Employers' Mental Health Benefits Remain Limited Despite New Federal Standards

Mr. Chairman and Members of the Committee:

We are pleased to be here today to discuss the implementation of the Mental Health Parity Act of 1996. An estimated 40 million American adults suffer from some type of mental illness each year. Private health insurance plans typically provide levels of coverage for the treatment of mental illness that are lower than coverage levels for the treatment of other illnesses. Consequently, patients with severe mental illness can exhaust their mental health coverage before they are fully treated. As you know, the Mental Health Parity Act of 1996 helps address the discrepancies in coverage between mental health and other illnesses by establishing a new federal standard for mental health coverage offered under most employer-sponsored group health plans. Specifically, the law requires parity in dollar limits by prohibiting employers from imposing annual and lifetime dollar limits on mental health coverage that are more restrictive than limits imposed on all medical and surgical coverage. Without legislative action, the federal law will sunset on September 30, 2001.

We recently issued a report, prepared at your request, examining the implementation and effects to date of the federal parity law.[1] My remarks today will focus on our findings concerning (1) employers' compliance with the law and the changes they have made to their health benefit plans, (2) what is known about the costs of complying with the law, and (3) the oversight roles of the Department of Health and Human Services (HHS) and the Department of Labor (DOL) in enforcing this law.

In brief, we found that most—but not all—employers we surveyed reported that they comply with the law by having parity in mental health and medical and surgical annual and lifetime dollar limits. Among the 863 employers responding to our survey that offered mental health benefits in the 26 states and the District of Columbia with laws no more comprehensive than the federal law, the percentage reporting parity in dollar limits grew from 55 percent in 1996 (before the law was effective) to 86 percent in 1999. However, most of these newly compliant employers reported that they also made changes to make their plans more restrictive in the number of hospital days or outpatient visits covered for mental health than for other medical and surgical benefits. Very few employers reported that the law resulted in higher claims costs. Finally, the Mental Health Parity Act and other recent federal health insurance standards have expanded DOL's role in regulating health benefits and have created a

[1] *Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited* (GAO/HEHS-00-95, May 10, 2000).

regulatory role for HHS' Health Care Financing Administration (HCFA) that entails federal enforcement of the law when states do not adopt conforming insurance regulations. While HCFA has begun to review state conformance, it has not completely determined the full extent of its required oversight role or specific time periods for making this determination.

Background

Private employer-sponsored health insurance plans typically provide lower levels of coverage for the treatment of mental illness than for the treatment of other illnesses. Issuers of coverage—employers that fund their own health plans and health insurance carriers—often limit mental health coverage through plan design features that can be more restrictive for mental health benefits than for medical and surgical benefits. Commonly found are lower service limits for mental health benefits such as the number of covered hospital days or outpatient office visits and higher cost-sharing features for mental health benefits such as deductibles or copayments.

Issuers limit mental health coverage primarily because of their concern about the high costs associated with long-term, intensive psychotherapy and extended hospital stays. An issuer may also restrict mental health benefits to protect itself from adverse selection. That is, a plan with relatively generous mental health benefits may be more likely to attract a disproportionate number of individuals who have high demands for mental health care services, thus driving up the claims and premium costs of the plan.

The Mental Health Parity Act of 1996 amended the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act to require that employer-sponsored health plans have annual and lifetime dollar limits for mental health coverage that are no more restrictive than those for all medical and surgical coverage.[2] The law does not apply to

- plans sponsored by an employer with 50 or fewer employees,
- group plans that experience an increase in plan claims costs of at least 1 percent because of compliance, or

[2]The Mental Health Parity Act of 1996, P.L. 104-204, title VII, 110 Stat. 2847, 2944-50 (to be classified at 29 U.S.C. 1185a and 42 U.S.C. 300gg-5).

- coverage sold in the individual (nongroup) market.

Furthermore, the law does not require any plan to offer mental health coverage, excludes substance abuse treatment, and does not prevent a plan from imposing more restrictive service limits (hospital days or outpatient visits) or higher cost-sharing requirements on mental health coverage than on medical and surgical coverage. The law became effective for group health plans for plan years beginning on or after January 1, 1998.

Within the past decade, most states also passed laws regulating mental health benefits. As of March 2000, the National Conference of State Legislatures' (NCSL) Health Policy Tracking Service reported that 43 states and the District of Columbia had laws in effect addressing mental health benefits in employer-sponsored group health plans.[3] Twenty-nine states have laws that are more comprehensive than the federal parity law and require parity not only in dollar limits but also in service limits or cost-sharing provisions. Sixteen of these states require full parity. That is, they mandate that mental health coverage be included in all group plans sold, and they require parity in all respects, including dollar limits, service limits, and cost sharing. Laws in six states essentially parallel the federal law by only requiring parity for annual and lifetime dollar limits and not requiring parity in services or cost-sharing provisions. Laws in eight states and the District of Columbia are more limited and might not conform to the federal law, and seven states have no laws addressing mental health benefits. Appendix I compares state laws addressing mental health benefits with the federal Mental Health Parity Act.

Enforcement authority for the Mental Health Parity Act is divided between federal agencies and the states. DOL is responsible for ensuring that private employer-sponsored group health plans comply with the law—an extension of DOL's regulatory role under ERISA.[4] In states that do not adopt and enforce statutes or regulations that meet or exceed the federal parity standards, HCFA is responsible for directly enforcing the federal insurance standards on carriers. In states that have standards conforming

[3]A smaller number of state laws also apply to coverage sold in the individual insurance market.

[4]ERISA allows employers to offer uniform national health benefits by preempting states from directly regulating employer-sponsored benefit plans. As a result, states are unable to directly regulate self-funded plans but can regulate health insurers. Under ERISA, DOL is responsible for ensuring that employer-sponsored group health plans meet certain fiduciary, reporting, disclosure, and appeals requirements related to the provision of health benefits.

to the federal parity law, state insurance regulators have primary enforcement authority over insurance carriers.[5]

To determine employers' responses to the law, we surveyed 1,656 employers subject to the law, which statistically represented 103,000 employers in the District of Columbia and 26 states. We obtained a response rate of 52 percent. Because our goal was to measure the effect of federal rather than state parity requirements, we surveyed employers with more than 50 employees in the 26 states and the District of Columbia that did not have state laws that were more comprehensive than the federal law as of July 1999.[6] To identify actions the federal agencies have taken to ensure compliance with the law, we interviewed officials from HCFA and DOL's Pension and Welfare Benefits Administration.

Most Employers Report Compliance With the Federal Law but Continue to Limit Mental Health Benefits

Employers we surveyed reported that they are largely complying with the federal mental health parity law. Eighty-six percent of the employers responding to our survey reported complying with the federal parity requirement, as of December 1999, representing about 68,000 to 74,000 employers in the 26 states and the District of Columbia. However, 14 percent reported that they were noncompliant, representing about 9,000 to 13,000 employers. Both HCFA and DOL officials found the 14 percent noncompliance rate comparable to their own assessments. For example, DOL recently determined from a preliminary review of about 200 employers' health plans it investigated that 12 percent were out of compliance with federal parity standards.

The law has resulted in more employers reporting parity in dollar limits for mental health and medical and surgical benefits. In 1996, before the federal parity law was enacted, only about 55 percent of employers we surveyed reported parity in the annual and lifetime dollar limits for mental

[5]This federal and state regulatory scheme applies to other federal health insurance standards, including those established under the Health Insurance Portability and Accountability Act of 1996, the Newborns' and Mothers' Health Protection Act of 1996, and the Women's Health and Cancer Rights Act of 1998.

[6]GAO/HEHS-00-95 contains further details of our survey and the limitations of our data. Our survey population included all 21 states and the District of Columbia that had no law, a law more limited than the federal law, or a law that meets the federal law based on our review of data that NCSL provided (see app. I). We also surveyed employers in five states identified as exceeding the federal law because (1) two states implemented more comprehensive laws after we selected our sample, (2) two states mandate that mental health benefits be included in most coverage sold but otherwise mirror the federal parity law by requiring parity only in dollar limits, and (3) one state had unclear statutory language and was included by HCFA in its initial determination that the state may not be enforcing the minimum federal standards.

health and medical and surgical benefits.[7] When employers were asked why they changed their annual or lifetime dollar limits, more than 75 percent of those responding cited the federal Mental Health Parity Act as a significant or primary reason. Among the employer plans in our survey that were not in compliance with the federal parity law, most had lifetime limits for mental health coverage of $100,000 or less.

Most employer plans we surveyed contained other plan design features that were more restrictive for mental health than for medical and surgical benefits. Typically, these features included limits on the number of covered hospital days and outpatient office visits as well as higher cost sharing such as copayments and coinsurance. As of December 1999, 87 percent of compliant employer plans contained at least one more restrictive provision for mental health benefits.[8] Most prevalent were restrictions on the number of outpatient office visits and hospital day limits, with nearly two-thirds of compliant employer plans having lower limits for mental health than for medical and surgical benefits. Very few employers we surveyed imposed any limits on office visits or hospital days for nonmental health conditions—about 8 and 10 percent, respectively.

Many employers in the states we surveyed changed mental health benefit design features specifically to mitigate the more generous annual and lifetime dollar limits required by the Mental Health Parity Act. About 65 percent of employers that changed annual or lifetime dollar limits after 1996 to be no less restrictive than dollar limits for medical and surgical coverage also changed at least one other mental health design feature to a more restrictive one. Most commonly changed were outpatient office visit limits and hospital day limits, as shown in table 1. Only 26 percent of employers that did not change dollar limits after 1996—that is, plans that were already in compliance or that remained out of compliance—changed at least one mental health design feature to something more restrictive.

[7]Because of respondent uncertainty and item nonresponse, we could not determine parity for 51 percent of employers in 1996. We were less likely to determine parity for both small employers (51 to 100 employees) and those in the South compared with employers of other sizes and in other areas of the country.

[8] As of December 1999, noncompliant plans did not differ significantly from compliant plans, with about 93 percent of noncompliant plans also containing at least one such restriction.

Table 1: Employer Plans That Have Added Restrictive Mental Health Benefits Provisions Since 1996

Change	Employers newly compliant with parity requirement	Other employers[a]
Fewer office visits covered	51%	11%
Fewer hospital days covered	36	11
Increased outpatient office visit copayments[b]	20	13
Increased outpatient office visit coinsurance	11	3
Increased cap on enrollee out-of-pocket costs	18	7
Increased hospital stay coinsurance	7	2
Increased hospital stay copayments[b]	3	7

[a]Includes employer plans that already had parity in 1996 and those that did not have parity in 1996 and remained out of compliance in 1999.

[b]The differences in the percentage of newly compliant and other employers that have increased hospital stay and office visit copayments since 1996 are not statistically significant.

Source: GAO survey of employers' mental health benefits.

Most Employers Are Not Aware of the Law's Effect on Claims Costs, Which Appears to Be Negligible

About 60 percent of the responding employers did not know whether compliance with the Mental Health Parity Act increased their plans' claims costs, and about 37 percent reported that compliance had not raised their claims costs. Only about 3 percent of the respondents reported that claims costs rose as a result of the act.[9] However, as noted above, compliance with the act was associated with a greater number of other restrictive provisions for other plan features, such as office visit or hospital day limits, which may have limited the extent to which claims costs would rise. Also, some employer-sponsored plans have increased their use of managed care techniques to better coordinate and control the use of mental health services. Moreover, less than 1 percent of responding employers have actually dropped coverage of mental health benefits or their health benefits plan altogether since the law was enacted, and most cited business reasons other than the cost of implementing the act's requirements for dropping coverage.

[9]The act allows an exemption for group plans that experience an increase in health benefit costs of 1 percent or more because of compliance with the law's requirements. Federal agencies estimated that as many as 10 percent of health plans affected by the law, or 30,000 health plans, could be eligible for the exemption. However, as of March 2000, DOL officials reported that only nine employers nationally had claimed an exemption.

Studies aimed at predicting the costs of the federal parity law generally corroborate our finding that requiring parity only in dollar limits resulted in cost increases of less than 1 percent. For example, in 1996, the Congressional Budget Office estimated that the Mental Health Parity Act would result in claims cost increases of 0.16 percent, and Coopers and Lybrand predicted that claims costs would rise by about 0.12 percent.[10] We are not aware of any additional studies after 1996 that have quantified the change in costs resulting from the federal parity requirements.

Most states (29) have enacted mental health laws that are more comprehensive than the federal Mental Health Parity Act and that are thus likely to have a greater effect on claims costs (see app. I). Unlike the federal law, these laws require parity not only in dollar limits but also in service limits, cost-sharing provisions, or both. In addition, many state laws mandate the inclusion of mental health benefits in fully insured group health plans and cover substance abuse and chemical dependency. Public and private health policy researchers have examined the estimated or actual costs resulting from more comprehensive state parity laws. In addition to estimating increased claims costs in several states, several studies have examined the potential premium cost increases associated with full parity nationally. Most of these studies have estimated the cost increase for full parity in individual states and nationally to be between 2 and 4 percent. These estimates represent a composite of the cost increases for fee-for-service, preferred provider organization, point-of-service, and health maintenance organization (HMO) plans. Typically, estimates assume that HMO and other managed care plans will have lower cost increases than fee-for-service plans.

[10]Coopers and Lybrand, *An Actuarial Analysis of S.2031, "The Mental Health Parity Act of 1996*" (n.p.: Sept. 1996).

Federal Agencies Have Made Varying Progress in Overseeing the Parity Law

DOL has traditionally relied on a complaint-driven approach to identify noncompliance with federal health plan standards. However, with the enactment of several federal health insurance reforms since 1996, including the Mental Health Parity Act, DOL's enforcement role has significantly expanded. Accordingly, it has undertaken several initiatives to improve and expand its oversight, customer service function, and consumer and employer education efforts.[11] On April 6, 2000, DOL published its strategic enforcement plan to make public its goals and intended approach to ensuring that employee benefit plans comply with federal standards, including mental health parity.

In particular, DOL has begun to rely on investigations to more systematically determine health plan compliance. As of March 2000, DOL officials said that they had completed investigating approximately 200 employers that varied by size and geography. In addition to reviewing employers' compliance with other health and pension standards, DOL found that 12 percent of these employers' health plans that were subject to the Mental Health Parity Act were not in compliance. These plans typically retained annual or lifetime limits that were lower for mental health coverage than for medical and surgical coverage or contained other violations of the law. According to officials, DOL sends letters to noncomplying employers outlining the violations and in the vast majority of instances is able to work with the employers to correct them without resorting to litigation. DOL plans to regularly conduct more investigations, perhaps as many as 1,000 annually, to help evaluate compliance.

HCFA has a new regulatory role since the enactment of the Mental Health Parity Act and other recent federal insurance reforms. The agency must enforce federal requirements in states where it determines that legislation has not been enacted that meets or exceeds the federal standards or has otherwise failed to "substantially enforce" the federal standards. HCFA's activities in support of this role have been evolving since the Health Insurance Portability and Accountability Act (HIPAA) was enacted in 1996.[12] On August 20, 1999, HCFA issued enforcement regulations that

[11]For additional information on DOL's initiatives, see *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100, May 12, 1999) and *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators* (GAO/HEHS-98-67, Feb. 25, 1998).

[12]For additional information on HCFA's activities, see *Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States* (GAO/HEHS-00-85, Mar. 31, 2000), (GAO/HEHS–99-100), (GAO/HEHS-98-67), and *Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws* (GAO/HEHS-98-217R, July 22, 1998).

prescribe how it assumes an enforcement role in a particular state and describe regulatory responsibilities it may perform.[13]

In mid-1999, HCFA undertook an initial state-by-state analysis of whether state laws conform to the federal standards—a precursor to its determining whether it is required to play an enforcement role in a particular state. HCFA officials said that this preliminary examination identified 7 states that appeared not to have laws addressing the federal parity standards, 24 states with laws about which the agency has questions concerning their conformance to the federal standards, and 20 states with laws that appeared to conform fully.

In December 1999, HCFA sent letters to the seven states that appeared not to have laws, indicating that it had a reason to question whether a state's standards substantially met the specified federal parity requirements. As of May 2000, HCFA officials said that four of these states have enacted conforming laws or other directives or have otherwise demonstrated that they enforce the federal parity requirements. In any of the remaining three states that do not meet standards through other regulatory means, HCFA will begin its formal determination process in which it could ultimately assume direct enforcement responsibilities. As of April 2000, HCFA was continuing to examine the 24 other states where it had questions concerning conformance, but it has not provided a specific time period for the completion of this review or the initiation of the formal determination process.

Concluding Observations

The Mental Health Parity Act of 1996 sought to bring mental health benefits closer to parity with other health benefits. However, the scope of the law applies only to annual and lifetime dollar limits, allowing most employer-sponsored health plans to use other features, particularly hospital and office visit limits, to continue to provide less coverage for mental health than for other health services. The net effect is that consumers in states without more comprehensive laws have often seen only minor changes in their mental health benefits, resulting in little or no increase in their access to mental health services, and that the costs associated with the federal law have been negligible for most health plans. More than half of the states have enacted more comprehensive parity laws, requiring parity not only in dollar limits but also in service limits, cost-sharing requirements, or both, some of which have estimated cost increases of about 2 to 4 percent. Nonetheless, because the more comprehensive state laws apply only to a portion of the population and the

[13]64 *Fed. Reg.* 45,786 (45 C.F.R. Pt. 144, 146, 148, and 150).

federal law applies only to dollar limits and is disregarded by a significant minority of employers, many Americans are likely to remain in employer-sponsored health plans that continue to provide less coverage for mental illness than for other types of illnesses.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer questions from you and other members of the Committee.

GAO Contacts and Acknowledgments

For more information regarding this testimony, please contact Kathryn G. Allen at (202) 512-7114 or John Dicken at (202) 512-7043. JoAnne Bailey, Randy DiRosa, Mary Freeman, and Betty Kirksey also made key contributions to this statement.

State Laws Affecting Mental Health Benefits Compared With the Federal Mental Health Parity Act

State	No law	More limited than federal law[a]	Meets federal law[b]	Exceeds federal law[c]	Full parity[d]
Alabama	X				
Alaska			X		
Arizona			X		
Arkansas				X	X
California[e]		X			
Colorado				X	X
Connecticut				X	X
Delaware				X	X
District of Columbia		X			
Florida			X		
Georgia				X	
Hawaii				X	X
Idaho	X				
Illinois		X			
Indiana				X	
Iowa	X				
Kansas				X	
Kentucky				X	
Louisiana				X	X
Maine				X	X
Maryland				X	X
Massachusetts		X			
Michigan	X				
Minnesota				X	
Mississippi		X			
Missouri				X	
Montana				X	X
Nebraska				X	
Nevada				X	
New Hampshire				X	X
New Jersey				X	X
New Mexico[f]			X		
New York				X	
North Carolina				X	
North Dakota		X			
Ohio		X			
Oklahoma				X	X
Oregon[g]	X				
Pennsylvania				X	
Rhode Island				X	X
South Carolina			X		
South Dakota				X	X
Tennessee				X	
Texas				X	
Utah	X				
Vermont				X	X
Virginia				X	X

State	No law	More limited than federal law[a]	Meets federal law[b]	Exceeds federal law[c]	Full parity[d]
Washington		X			
West Virginia			X		
Wisconsin		X			
Wyoming	X				
Total	**7**	**9**	**6**	**29**	**16**

Note: State laws in effect as of March 1, 2000.

[a]Law addresses mental health benefits but does not require parity in dollar limits. However, the law may require mandated mental health benefits, impose minimum service levels, or place limits on cost-sharing features for mental health benefits.

[b]Law requires parity in dollar limits but not in services or cost sharing.

[c]Law requires parity in dollar limits and requires parity in services or cost sharing or requires mandated mental health benefits.

[d]Law requires parity in all respects—dollar limits, services, and cost sharing—and also requires mandated mental health benefits.

[e]A law that exceeds the federal law becomes effective July 2000.

[f]A law that exceeds the federal law becomes effective October 2000.

[g]A law more limited than the federal law becomes effective July 2000.

Source: GAO review of data compiled by Tracy Delaney, the National Conference of State Legislatures' Health Policy Tracking Service.

Related GAO Products

Mental Health Parity Act: Despite New Federal Standards, Mental Health Benefits Remain Limited (GAO/HEHS-00-95, May 10, 2000).

Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States (GAO/HEHS-00-85, Mar. 31, 2000).

Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards (GAO/HEHS-99-100, May 12, 1999).

Private Health Insurance: HCFA Cautious in Enforcing Federal HIPAA Standards in States Lacking Conforming Laws (GAO/HEHS-98-217R, July 22, 1998).

Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, Regulators (GAO/HEHS-98-67, Feb. 25, 1998).

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